MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Oxymed, Inc. P O Box 972557 Dallas, Texas 75397-2557	MDR Tracking No.: M4-04-4234-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address TPCIGA for Legion Insurance Company Box 05	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: EL-28-24-00405-001

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
03/25/03	03/25/03	E0731	$99.00	$99.00
05/19/03	05/19/03	E0745	$352.00	$352.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "Our charges were billed consistently with the medical policies and fee guidelines as established by the commission. Attached you will find the signed prescription form the patient's treating doctor, descriptions of the equipment purchased, as well as examples of payments made in full by other carriers for the same exact equipment which supports the fact that we the provider bill at 'Fair and Reasonable'."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier did not submit a position statement. Carrier's EOB denial is "F-Equipment, supplies, or nonpharmacy meds need copy of prescription and medical necessity to be considered. F-If reduction, then processed according to the Texas Fee Guidelines."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

HCPCS codes E0731 and E0745 should be billed at the usual and customary rate of the DME provider. Carrier shall reimburse at a fair and reasonable rate per the MFG DME IX (C).

Per Commission Rule 133.307(j)(f), the reimbursement for these items would be at a "fair and reasonable" rate.

The requestor submitted product information and redacted EOBs from other carriers indicating a fair and reasonable reimbursement that indicates that their charges were fair and reasonable per rule 133.307(g)(3)(D).

Therefore, based on this information additional reimbursement is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$451.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled reimbursement in the amount of **$451.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the requestor within 20-days in receipt of this Order.

Ordered by:

Authorized Signature	Michael Bucklin	12/27/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____